

NEW EMPLOYMENT VERIFICATION FORM

TO: _____

DATE: _____
RE: _____
SSN: _____ DOB: _____

Dear Sir:

Employment information on the above-named individual is being requested. Your immediate attention to this matter is appreciated. Please respond by _____. Thank you.

ELIGIBILITY WORKER UNIT ADDRESS/ TELEPHONE NUMBER

I, _____ hereby give permission for the release of information to the Department of Human Services regarding my employment and earnings.

APPLICANT/RECIPEINT'S SIGNATURE DATE

1. Date of hire: _____ Full-time _____ Part-time _____
2. Rate of pay: \$ _____ per _____ Salaried? Yes _____ No _____
3. Dates paid in the month? _____
4. Pay period ends (e.g., 15th and 30th, Sundays, etc.): _____

5. Number of hours anticipated per day: _____ Days per week: _____
6. Scheduled work days? (e.g. Monday thru Friday, Saturday only): _____

7. First pay expected: _____ For period: _____ to _____
8. Medical/dental insurance carrier(s) coverage: _____
Plan number(s): _____ Effective date(s) of coverage: _____
Type of coverage (e.g., Basic, Drug, Vision, Dental): _____
Name of persons covered by plan: _____

9. Position title and job responsibilities: _____

10. Other comments (tips, commissions, etc.): _____

SIGNATURE OF PERSON PROVIDING INFORMATION DATE

(PRINT/TYPE) NAME TITLE TELEPHONE NUMBER